

# SALIX ENROLLMENT FORM

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Social Security No \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Sex  M  F Weight \_\_\_\_\_ Height \_\_\_\_\_ Allergies \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work/Mobile \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PATIENT INSURANCE INFORMATION

Primary Medical Insurance \_\_\_\_\_ Medical Insurance Phone \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Rx Card (PBM) \_\_\_\_\_ Group No \_\_\_\_\_  
 Prescription Card Bin # \_\_\_\_\_ PCN # \_\_\_\_\_

## TREATMENT ARRANGEMENTS

•Start Date: \_\_\_\_\_ Ship Meds  Home  Doctor's Office

## STATEMENT OF MEDICAL NECESSITY

### DIAGNOSIS:

- IBS-D (K 58.0)  Travelers diarrhea (A09)  Hepatic Encephalopathy (K 72.90)  Ulcerative Colitis (K 51.40)  
 Other: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_ Prior Medications: \_\_\_\_\_  NKDA

## PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> PLENVU	<input type="checkbox"/> 1Kit	<input type="checkbox"/> Use as directed. <input type="checkbox"/> Others :		
<input type="checkbox"/> LUCEMYRA	<input type="checkbox"/> 0.18mg	<input type="checkbox"/> Take 3 tabs by mouth QID days 1-7, take 2 tabs by mouth QID on day 8 and take 1 tab by mouth QID on day 9 with or without food. <input type="checkbox"/> Others :		
<input type="checkbox"/> XIFAXAN (HE)	<input type="checkbox"/> 550mg	<input type="checkbox"/> Take one tablet by mouth BID with or without food as directed. <input type="checkbox"/> Others :	<b>60</b>	
<input type="checkbox"/> XIFAXAN (IBS-D)	<input type="checkbox"/> 550mg	<input type="checkbox"/> Take one tablet by mouth TID for 14 days with or without food as directed. <input type="checkbox"/> Others :	<b>42</b>	
<input type="checkbox"/> UCERIS	<input type="checkbox"/> 9mg	<input type="checkbox"/> Take one tablet by mouth Once a day. <input type="checkbox"/> Others :		
<input type="checkbox"/> RELISTOR	<input type="checkbox"/> 150mg	<input type="checkbox"/> Take 3 tablets by mouth every morning 30 minutes prior to breakfast. <input type="checkbox"/> Others :		
<input type="checkbox"/> TRULANCE	<input type="checkbox"/> 3mg	<input type="checkbox"/> Take one tablet by mouth Once a day. <input type="checkbox"/> Others :	<b>90</b>	

Physician Signature: **X** \_\_\_\_\_  DAW (Dispense as Written) Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Physician Address: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

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